# BENEFICIARY PROBLEM RESOLUTION PROCESS

## *OVERVIEW OF GRIEVANCE AND APPEAL PROCEDURES*

San Diego County Mental Health Services is strongly committed to honoring the rights of every consumer to have access to a fair, impartial, effective process through which the consumer can seek resolution of a problem encountered in accessing or receiving quality mental health services. The following grievance and appeal procedures are designed to ensure that problems can be addressed quickly and thoroughly, so that the individual can proceed toward the chosen goals on his or her road to recovery.

The process is designed to be simple to access and supportive of the individual's rights. It is action-oriented, and seeks to offer timely resolution of the concerns of the individual, as well as ultimately to increase the quality of services for other consumers in the population. Clients always have the option of bringing an issue directly to the provider of care. In addition, there are three problem resolution processes. They are:

1) the grievance process,
2) the appeal process (in response to an "action" as defined below), and
3) the expedited appeal process (available in certain limited circumstances).

A fourth option, the State Fair Hearing, is an option available to Medi-Cal beneficiaries who have taken an appeal through the County MHP process and are dissatisfied with the resolution. Also, clients who have taken a grievance or appeal through the County MHP process and experienced a delay in problem resolution beyond the mandated timeline for completion, without giving permission for an extension, may request a State Fair Hearing; they need not wait until the completion of the County process to do so.

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, SED-certified children through the Healthy Families program, and persons without Medi-Cal funds receiving county-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5, Section 1850.205 and 42 CFR Subpart F, Part 438.400. The procedures relating to children and youth served under AB 3632/2726 legislation will take precedence over this document. By law, Welfare and Institution (WI) Code WI 10950, the State Fair Hearing process, is only available to a Medi-Cal beneficiary.

## *I. OBJECTIVES OF THE GRIEVANCE AND APPEAL POLICY*

The objective of the Grievance and Appeal policy is to:

- To provide the consumer with a process for independent resolution of grievances and appeals.
- To protect the rights of consumers, including the right to:
  - be treated with dignity and respect,
  - be treated with due consideration for his or her privacy,
  - receive information on available treatment options in a manner appropriate to his or her condition and ability to understand,
  - participate in decisions regarding his or her mental health care, including the right to refuse treatment,
  - be free from any form of unnecessary restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,

- request a copy of his or her medical records, and to request that an additional statement amending or correcting the information be included, and
- freely exercise these rights without adverse effects in the way providers treat him or her.

- To protect the rights of consumers during grievance and appeal processes.
- To assist individuals in accessing medically necessary, high quality, consumer-centered mental health services and education.
- To respond to consumer concerns in a linguistically appropriate, culturally competent and timely manner.
- To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites.

## *II. DEFINITIONS*

**ASO:** Administrative Service Organization contracted by HHSA to provide Managed Care Administrative functions.

**Action:** As defined by 42 Code of Federal Regulations (CFR) an action occurs when the Mental Health Plan (MHP) does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as determined by the MHP or;
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

**Advocate**: A person who is available to help consumers through the grievance and/or appeal process.

**Appeal:** A request for review of an action (as action is defined above).

**Beneficiary:** A client who is Medi-Cal eligible and currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan.

**Client:** Any individual currently receiving mental health services from the County MHS system, regardless of funding source.

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| **Consumer Center for Health Education and Advocacy (CCHEA):** | The Consumer Center for Health Education and Advocacy is an agency currently designated by the Local Mental Health Director to provide information, education and advocacy services. This includes investigation of patients' rights issues raised by consumers in outpatient services. |
| **Consumer:** | Any individual who is currently requesting or receiving specialty mental health services, regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.) |
| **Grievance:** | An expression of dissatisfaction about any matter other than an action (as action is defined). |
| **Grievance and Appeal Process**: | A process for the purpose of attempting to resolve consumer concerns regarding specialty mental health services. |
| **Local Mental Health Director**: | The County-designated Local Mental Health Director, as appropriate for Children and Adults. |
| **Mental Health Plan (MHP):** | County of San Diego, Health & Human Services Agency, Mental Health Services. |

**Notice of Action (NOA):** A notice sent to Medi-Cal beneficiaries to inform them of a decision regarding denial, reduction, or termination of requested services and their rights for appeal if they disagree with the decision.

NOA-A: (Assessment) Denial of service sent from providers to Medi-Cal beneficiaries when the face-to-face assessment indicates they do not meet medical necessity criteria and no specialty mental health services will be provided.

NOA-B: (Denial of Services) Denial or modification of provider's request for services requiring pre-authorization sent from the point of authorization to both provider and beneficiary when the beneficiary did not receive the service.

NOA-C: (Post-Service Denials) Denial or modification of provider's request for specialty mental health services sent from the point of authorization to both the provider and the beneficiary, when the beneficiary has already received the service.

NOA-D: (Delayed Grievance/Appeal Decisions) Notice sent by advocacy contractor to the beneficiary when the resolution of the grievance, appeal or expedited appeal was not provided within the required timeframe.

NOA-E: (Lack of Timely Services) Notice sent by provider to beneficiary when the provider does not provide services in a timely manner according to the MHP standards for timely services.

**Patients' Rights Advocate:** The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services, and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries.

USD Patient Advocacy Program is currently the Patients' Rights Advocate for acute inpatient and other 24-hour residential services, and CCHEA is the Patients' Rights Advocate for outpatient, day treatment, and all other services.

**Quality Improvement (QI) Program:** The Quality Improvement Program is a unit within HHSA Mental Health Services whose duties include monitoring and oversight of the Grievance and Appeal Process.

**State Fair Hearing:** A formal hearing before an administrative law judge, requested by a Medi-Cal beneficiary and conducted by the State Department of Social Services as described in Welfare and Institutions Code, Section 10950, and Federal Regulations Subpart E, Section 431.200 et seq.

**University of San Diego (USD) Patient Advocacy Program:** The University of San Diego Patient Advocacy Program is an agency currently designated by the Local Mental Health Director to provide information, education and advocacy services. This includes investigation of patients' rights issues raised by consumers receiving mental health services in acute care hospitals and other 24-hour care settings.

## *III. GRIEVANCE AND APPEAL POLICY*

The Mental Health Plan (MHP) has established policies for addressing and resolving grievances and appeals regarding specialty mental health services in accordance with State and federal regulations. Expressions of dissatisfaction registered by the direct recipient of such services and/or persons acting on his/her behalf shall be responded to in accordance with the following policies.

**General Policies Regarding Grievances and Appeals**

- Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.
- Clients' rights and confidentiality shall be protected at all stages of the grievance and appeal process by all providers and advocates involved.
- Consumers shall be informed of their right to contact the USD Patient Advocacy Program or CCHEA at any time, for assistance in locally resolving a grievance or appeal. Medi-Cal beneficiaries shall also be informed of their right to request a State Fair Hearing.
- Consumers of the MHP and persons seeking services shall be informed of the process for resolution of grievances and appeals. This will include information about the availability of the USD Patient Advocacy Program and the Consumer Center for Health Education and Advocacy (CCHEA), the programs that will have responsibility for assisting consumers with the problem resolution processes at the consumer's request. The information shall be available in the threshold languages and shall be given to the client at the point of intake to Mental Health Plan services and upon request during the provision of services. Continuing clients must be provided with the information annually and providers will document these efforts.
- The client may authorize another person or persons to act on his/her behalf. A client may select a provider as his or her representative in the appeal process. His or her representative, or the legal representative of a deceased client's estate, shall be allowed to be included as parties to an appeal.
- A support person chosen by the client, such as family member, friend or other advocate may accompany them to any meetings or hearings regarding a grievance or appeal.
- The client and/or his or her representative may examine the case file, including documents or records considered during the grievance or appeal process.
- Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to file a grievance or appeal.
- Advocates shall treat clients, their chosen support persons, and all providers with courtesy and respect throughout the grievance resolution process.

- Providers shall participate fully and in a timely manner in order to honor the client's right to an efficient, effective problem resolution process.
- Clients who are Medi-Cal beneficiaries, who have taken an appeal through the MHP Beneficiary Problem Resolution process and are dissatisfied with the resolution, have the right to request an impartial review in the form of a State Fair Hearing within 90 days of the decision or whether or not the client received a Notice of Action (NOA). At a State Fair Hearing, a client has the opportunity to present his or her concerns to an administrative law judge for a ruling. (See Section VII.)
- Clients who are Medi-Cal beneficiaries and who have a grievance or appeal which has not been resolved by the MHP within mandated timelines, and no client permission for an extension has been granted, may request a State Fair Hearing. They need not wait until the end of the County process before making the request.
- Quality of care issues identified as a result of the grievance and appeal process shall be reviewed by the MHP and the Quality Review Council for implementation of system changes, as appropriate.

**Policies Regarding Notification of Grievance and Appeal Procedures**

- Consumers shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact USD Patient Advocacy and CCHEA. The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and, as appropriate, during the provision of services. Continuing clients must be provided with the information annually and providers will document these efforts.
- Notices describing mental health rights, as well as the grievance and appeal procedures, shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the County's threshold languages.
- Grievance/Appeal forms and self-addressed envelopes must be available for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of both locked and unlocked behavioral health units.
- CCHEA and Patient Advocacy Program shall have interpreter services and toll-free numbers with adequate TDD/TTY available at a minimum during normal business hours.
- Under certain circumstances, when the MHP denies any authorization for payment request from a provider to continue specialty mental health services to a Medi-Cal beneficiary, the MHP must provide the Medi-Cal beneficiary with a Notice of Action (NOA), which informs the beneficiary of his or her right to request a State Fair Hearing, and the right to contact a patient advocate.

## *IV. GRIEVANCE PROCEDURE*

Consumers are encouraged to direct matters to the therapist, case manager, facility staff, or other person involved in their care. This may be done orally or in writing. Often this is the quickest way to both make the provider aware of the client's issue, as well as come to a satisfactory resolution. However, no consumer shall be required to take the matter directly to the provider unless he or she chooses.

In addition to, or instead of, bringing the issue directly to the individual provider, consumers may work directly with the supervisor or Program Director, who shall make efforts to resolve it. In attempting to reach resolution, and consistent with confidentiality requirements, the appropriate supervisor or Program Director shall utilize whatever information, resources and/or contacts the consumer agrees to.

**Grievance Process**

At any time the consumer chooses, the consumer may submit the issue to CCHEA or USD Patient Advocacy as appropriate. CCHEA or USD Patient Advocacy shall work to resolve the issue according to the following steps:

1. Client contacts USD Patient Advocacy Program (for issues relating to inpatient and other 24-hour-care programs) or CCHEA (for issues relating to outpatient, day treatment and all other services) either orally or in writing to file a grievance. A grievance is defined as an expression of dissatisfaction about anything other than an "action."
   NOTE: If the client's concern is in regard to an "action" as it is defined above, the issue is an "appeal," not a grievance. See "Appeal Process" below for procedure.
2. CCHEA or Patient Advocacy Program logs the grievance within one working day of receipt. The log shall include the client name or other identifier, date grievance was received, date logged, nature of the grievance, the provider involved, and whether the issue concerns a child. The log is to be maintained in a confidential location at CCHEA or USD Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if so requested by the client.
3. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the grievance within three working days.
4. CCHEA or Patient Advocacy Program shall contact the provider involved in the grievance as soon as possible and within three working days of receipt of the client's written permission to represent the client.
5. CCHEA or Patient Advocacy Program evaluates the grievance.
   - They shall ensure that the person who will make the final determination regarding the resolution of the grievance has had no involvement in any previous level of review of decision-making in regard to the grievance in question.
   - The client's confidentiality shall be safeguarded per all applicable laws.
6. If the grievance is about a clinical issue, the decision maker must be a health care professional with the appropriate clinical expertise in treating the client's condition.
7. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's grievance, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, either in person or by phone at various points in the process. The expectation is that the advocate and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

   If a case should arise in which the advocacy organization (CCHEA or Patient Advocacy Program) and the provider are unable to reach a mutually agreeable resolution to the grievance within the required timeframe as stated below, the advocacy organization shall

make a finding based on the facts as they are known. The grievance disposition letter shall include this finding. The letter may include a request that the provider write a Plan of Correction to be submitted by the provider directly to the MHP Director or designee. The advocacy organization may also choose to include what they believe to be equitable, enforceable suggestions or recommendations to the provider for resolution of the matter. Notification of the resolution shall go out to all parties as described below.

8. CCHEA or Patient Advocacy Program shall notify the client in writing regarding the disposition of the grievance within the timeframe for resolution stated below. The notice shall include:
   - the date,
   - the resolution,

   A copy of the grievance resolution letter will be sent to the provider and the QI Unit at the time the letter is sent to the client.

9. Timelines for grievance dispositions cannot exceed 60 calendar days from the date of receipt of the grievance. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of grievance resolution is an important issue for consumers. If an extension is required, CCHEA or Patient Advocacy Program will contact the client to discuss an extension, clearly document in the file the extenuating circumstances that indicate the need for the extension, and the date the client was contacted and agreed to an extension. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay. If CCHEA or Patient Advocacy staffs are unable to meet the timeframe described herein, they shall issue a Notice of Action D (NOA-D) to the beneficiary informing them of their rights. A copy of the NOA-D shall be sent to the QI Unit. Clients whose grievances are not completed according to mandated timelines, and have not given permission for an extension, may request a State Fair Hearing. They need not wait until the end of the County process to make this request.

10. CCHEA or USD Patient Advocacy Program shall record in the log, the final disposition of the grievance, and date the decision was sent to the client, or reason there has not been a final disposition of the grievance.

11. Providers who do not successfully resolve the grievance with the advocacy organization during the grievance process shall receive two letters from CCHEA or USD. One is a copy of the disposition sent to the client, that includes a request for Plan of Correction, and the other is a letter requesting that the provider write a Plan of Correction and submit it within 10 working days directly to:

    Grievance Plan of Correction
    Quality Improvement Unit
    P.O. Box 85524, Mail Stop P531G
    Camino Del Rio South
    San Diego, CA 92186-5524

    The Plan of Correction letter to the provider (not the grievance disposition letter) may include the advocacy organization's suggestions of what the Plan of Correction could include. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the MHP. The monitoring of any provider's Plan of Correction and handling of any provider's request for administrative review shall be performed by the MHP directly with the provider.

In the event that a provider disagrees with the findings of the grievance investigation as decided by the advocacy organization, and does not agree to write a Plan of Correction, the provider may choose instead to write a request for administrative review by the MHP. This request shall be submitted directly by the provider to the MHP Director or designee within 10 working days of receipt of the grievance disposition. The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

Please note: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing a grievance.

## *V. APPEAL PROCEDURE*

The appeal procedure begins when a Medi-Cal beneficiary contacts USD Patient Advocacy Program (for issues relating to inpatient and other 24 hour care program) or CCHEA (for issues relating to outpatient, day treatment and all other services) to file an appeal to review an "action."

An "action" is defined by 42 Code of Federal Regulations as occurring when the MHP does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Delay in completion of the MHP appeals process within the mandated timeframe, without client permission for an extension.

In San Diego County this is relevant only for inpatient, day treatment, and outpatient services provided by fee-for-service individual and group providers, as these are currently the only services for which an authorization is required. Clients wishing to have a review of a clinical decision made by a provider, not the MHP or its administrative services organization, may use the grievance process.

**Appeals Process**:

1. CCHEA or Patient Advocacy Program determines whether the appeal meets the criteria for expedited appeal, and if so, follows the expedited appeal process as stated in section VI below.
2. CCHEA or Patient Advocacy Program logs the appeal within one working day of receipt. The log shall include the client name or other identifier, date appeal was received, date logged, nature of the appeal, the provider involved, and whether the issue concerns a child. The log is to be maintained in a confidential location at CCHEA or USD Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if so requested by the client.
3. The client may file the appeal orally or in writing. If the appeal is oral, the client is required (and provided with assistance as needed) to follow up with a signed, written appeal. The client may be assisted in completing the written appeal. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed.
4. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the appeal within three working days.

5. The client may present evidence in person or in writing.

6. CCHEA or Patient Advocacy Program shall contact the provider as soon as possible and within three working days of receipt of the client's written permission to represent the client.

7. CCHEA or Patient Advocacy Program shall notify the QI Unit within three working days of any appeal filed.

8. CCHEA or Patient Advocacy Program evaluates the appeal.

   - They shall ensure that the person who will make the final determination regarding the resolution of the appeal has had no involvement in any previous level of review of decision-making in regard to the appeal in question.
   - The client's confidentiality shall be safeguarded per all applicable laws.

9. If the appeal is about a clinical issue, the decision-maker must also be a health care professional with the appropriate clinical expertise in treating the client's condition.

10. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's appeal, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved and the ASO, either in person or by phone at various points in the process. The expectation is that the advocate, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

    If the advocacy organization shall deny the appeal, or if the appeal shall be granted but is not an appeal of one of the actions listed in item #11, proceed to item #13.

11. If the advocacy organization believes that there is sufficient merit to grant an appeal regarding an action that:
    - denied or limited authorization of a requested service, including the type or level of service,
    - reduced, suspended or terminated a previously authorized service, or
    - denied, in whole or in part, payment for a service,

    the advocacy organization shall do the following within 30 calendar days of the date the appeal was filed:

    a) notify the MHP Director or designee in writing of details of the appeal and the specific, supported rationale for why it should be granted, and

    b) provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the appeal.

12. The MHP Director or designee shall return a decision on the appeal to the advocacy organization within 10 calendar days of receipt of the above.

13. CCHEA or Patient Advocacy Program shall notify the client in writing regarding the disposition of the appeal within the timeframe for resolution stated below. The notice shall include:
    - the date,
    - the resolution, and
    - (only if the decision is not wholly in favor of the client AND the client is a Medi-Cal

beneficiary) the notice shall also include the information regarding the right to request a State Fair Hearing within 90 days of notice of the decision, along with information on how to request a State Fair Hearing, and information on the beneficiary's right to request services while the hearing is pending and how to make that request for continued services.

A copy of the appeal resolution letter will be sent to the provider and the QI Unit at the time the letter is sent to the client.

14. Appeals must be resolved within 45 calendar days from the date of receipt of the appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of appeal resolution is an important issue for consumers. If an extension is required, CCHEA or Patient Advocacy Program will contact the client to discuss an extension, clearly document in the file the extenuating circumstances that indicate the need for the extension, and the date the client was contacted and agreed to an extension.
15. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay. The notice shall include the client's right to file a grievance if the client disagrees with the decision to extend the timeframe.
16. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they shall issue an NOA-D to the beneficiary. A copy shall be sent to the QI Unit. CCHEA or USD Patient Advocacy Program shall record in the log, the final disposition of the appeal, and date the decision was sent to the client, or reason there has not been a final disposition of the appeal.
17. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.
18. Please note: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

## *VI. EXPEDITED APPEAL PROCESS*

1. When a client files an oral or written appeal to review an action (as defined above) and **using the standard appeal resolution process could, in the opinion of the client, the MHP, or CCHEA or USD Patient Advocacy program staff, jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function**, the expedited appeal process will be implemented instead.
2. If in the opinion of CCHEA or Patient Advocacy Program, the appeal does not meet the criteria for the expedited appeal process that has been requested, CCHEA or Patient Advocacy program staff shall:
   a) Obtain agreement of the MHP to deny the use of the expedited appeal process and to treat the appeal as a standard appeal instead,
   b) Transfer the appeal to the timeframe for standard appeal resolution (above), and
   c) Make reasonable efforts to give the client prompt oral notice of the denial of the expedited process, and follow up within two calendar days with a written notice. A copy of the letter shall be sent to QI.
3. CCHEA or Patient Advocacy Program logs the expedited appeal within one working day of receipt. The log shall include the client name or other identifier, date appeal was received,

date logged, nature of the appeal, the provider involved, and whether the issue concerns a child. The log is to be maintained in a confidential location at CCHEA or USD Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if so requested by the client.

4. The client may file the expedited appeal orally or in writing.

5. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the expedited appeal within two working days.

6. The client or his or her representative may present evidence in person or in writing.

7. CCHEA or Patient Advocacy Program shall notify the QI Unit immediately of any expedited appeal filed. CCHEA or Patient Advocacy Program shall contact the provider as soon as possible and not to exceed two working days.

8. CCHEA or Patient Advocacy Program evaluates the expedited appeal.

   - They shall ensure that the person who will make the final determination regarding the decision about the expedited appeal has had no involvement in any previous level of review of decision-making in regard to the action in question.
   - The client's confidentiality shall be safeguarded per all applicable laws.

9. If the expedited appeal is about a clinical issue, the decision-maker must also be a health care professional with the appropriate clinical expertise in treating the client's condition.

10. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's expedited appeal, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, and the ASO, either in person or by phone at various points in the process. The expectation is that the advocate, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

    If the advocacy organization shall deny the expedited appeal, or if the expedited appeal shall be granted but is not an appeal of one of the actions listed in item #11, proceed to item #13.

11. If the advocacy organization believes that there is sufficient merit to grant an expedited appeal regarding an action that:
    - denied or limited authorization of a requested service, including the type or level of service,
    - reduced, suspended or terminated a previously authorized service, or
    - denied, in whole or in part, payment for a service,

    the advocacy organization shall do the following within two working days of the date the appeal was filed:

    a) notify the MHP Director or designee in writing of details of the expedited appeal and the specific, supported rationale for why it should be granted, and
    b) provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the expedited appeal.

    The MHP Director or designee shall return a decision on the expedited appeal to the advocacy organization within one working day of receipt of the above.

12. CCHEA or Patient Advocacy Program shall make a reasonable effort to notify the client orally of the expedited appeal resolution decision as soon as possible. In addition, they shall

    notify the client in writing within the timeframe for resolution stated below, regarding the results of the expedited appeal. The notice shall include:
    - the date,
    - the resolution, and
    - (only if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary) the notice shall also include the information regarding the right to request an expedited State Fair Hearing, along with information on the beneficiary's right to request services while the hearing is pending and how to make that request for continued services.

    A copy of the appeal resolution letter will be sent to the provider and the QI Unit at the time the letter is sent to the client.

13. Expedited appeals must be resolved and the client must be notified in writing within three working days from the date of receipt of the expedited appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days if the client requests an extension. In rare circumstances, the timeframe may be extended up to the 14 calendar days if CCHEA or Patient Advocacy program staff determine that there is a need for more information AND that the delay is in the client's best interest.

14. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay.

15. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they shall issue an NOA-D to the beneficiary. A copy shall be sent to the QI Unit.

16. CCHEA or USD Patient Advocacy Program shall record in the log, the final disposition of the expedited appeal, and date the decision was sent to the client, or reason there has not been a final disposition of the expedited appeal.

17. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

18. Please note: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

## *VII. STATE FAIR HEARINGS*

In addition to the MHP's client problem resolution process there is an additional process available to clients who are Medi-Cal beneficiaries who filed an appeal regarding an action. These clients have the right to request an impartial review in the form of a State Fair Hearing within 90 days after the completion of the MHP beneficiary problem resolution process, whether or not the client received a Notice of Action (NOA).

Also, a beneficiary whose grievance or appeal has not been resolved within mandated timelines and who gave no permission for an extension, may request a State Fair Hearing. The beneficiary does not need to wait for the end of the MHP Problem Resolution process.

A State Fair Hearing is a legal process that includes a hearing and ruling by an administrative law judge. A Medi-Cal beneficiary may request a State Fair Hearing by writing to or calling the State Fair Hearings Division of the California Department of Social Services at 1 (800) 952-

5253, or by contacting CCHEA or USD Patient Advocacy Program for assistance.

When notified by the State Fair Hearings Division that a hearing has been scheduled, the MHP QI Unit staff shall contact the client or his or her advocate, and attempt to learn what the client is grieving and investigate the facts of the matter. The QI staff shall work to resolve the issue to the client's satisfaction without the need to proceed to a hearing. In cases where a successful resolution of the matter is not reached, the client proceeds to a hearing, and the QI staff attends the hearing to represent the MHP position. Staff of County-operated and/or contracted providers may occasionally be required to assist in the preparation of the MHP's position paper for a hearing in which they are the provider involved, and/or may be requested to attend the hearing as a witness in the case.

If a Medi-Cal beneficiary has met Aid Paid Pending criteria per CCR, Title 22, Section 51014.2 (i.e., made a request for fair hearing within 10 days of the date the NOA was mailed or given to the beneficiary – or, the effective date of the service change, whichever is later) the MHP must ensure that benefits are continued while a State Fair Hearing is pending. The benefits will stay the same until a final hearing decision is made adverse to the client, or the time period or service limits for the client's correct services expire, whichever happens first.

After a judge has heard a case, he or she forwards the decision to the MHP QI Unit. In the event that the case in not resolved in the MHP's favor, the QI Unit staff shall communicate the decision and any actions to be implemented, to the MHP Program Monitors to oversee implementation of the resolution by the County-operated and/or contracted providers.

## *VIII. PROCEDURES FOR MONITORING GRIEVANCES AND APPEALS*

The MHP QI Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.

- The MHP QI Unit shall review the files of CCHEA and USD Patient Advocacy program periodically and as frequently as needed in order to monitor timely adherence to the policy and procedures outlined herein, and ensure that consumer rights under this process are protected to the fullest extent.
- On a monthly basis, by the 20th of the next month, USD Patient Advocacy Program and CCHEA shall submit their logs of all grievances and appeals for the previous calendar month, to the MHP QI Unit. The logs shall specify whether each item is a grievance, appeal, or expedited appeal. They shall include the client name or other identifier, date grievance or appeal was filed, date logged, the nature of the grievance or appeal, the provider involved, and whether the issue concerns a child. For those grievances and appeals that have been resolved, the log shall note the final disposition of the grievance or appeal, and the date the decision was sent to the client.

The MHP QI Unit will keep centralized records of monitoring grievances and appeals including the nature of the grievance/appeal as well as track outcomes of appeals that were referred to other entities including State Fair Hearings. Trends will be identified and referred to the Quality Review Council, MHP Director, and/or Mental Health Board for recommendations or action as needed. The MHP QI Unit shall submit a grievance and appeal log to the State Department of Mental Health annually.